In the Supreme Court of the United States

OCTOBER TERM 1977

No. 77-1744

WILLIE R. BARNES, as Commissioner of Corporations of the State of California,

Petitioner,

v.

HEWLETT-PACKARD COMPANY, a California corporation, et al.,

Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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TO THE HONORABLE CHIEF JUSTICE AND ASSOCIATE JUSTICES OF THE SUPREME COURT OF THE UNITED STATES:

Willie R. Barnes, as Commissioner of Corporations of the State of California, the petitioner herein, prays that a writ of certiorari issue to review the judgment of the Court of Appeals for the Ninth Circuit entered in this proceeding on March 14, 1978.[1]

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1. The other respondents in this proceeding not named in the caption are STANDARD OIL COMPANY OF CALIFORNIA, a Delaware corporation, THE PACIFIC LUMBER COMPANY, a Maine corporation, THE PACIFIC LUMBER COMPANY EMPLOYEE BENEFIT ORGANIZATION, a nonprofit Delaware corporation, JOHN SCALONE AND FREDDY SANCHEZ, as trustees of the JOINT BENEFIT TRUST established by CALIFORNIA PROCESSORS, INC. and the CALIFORNIA STATE COUNCIL OF CANNERY AND FOOD PROCESSING UNIONS, WELLS FARGO AND COMPANY, a California corporation and the SOUTHERN CALIFORNIA DRUG BENEFIT FUND.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 571 F.2d 502 and is printed in Appendix A, *infra*, pages 1-6. The opinion of the District Court for the Northern District of California is reported at 425 Fed.Supp. 1294, and appears at Appendix B, *infra*, pages 7-22.

JURISDICTION

The judgment of the Court of Appeals for the Ninth Circuit was entered on March 14, 1978. See Appendix A, *infra*, page 1. This petition for a writ of certiorari was filed within 90 days of that date. The jurisdiction of the Supreme Court is invoked under 28 U.S.C. section 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

This case involves Article 1, section 8, clause 3 and Article 6, clause 2 of the United States Constitution; the Tenth Amendment to the United States Constitution; the Employee Retirement Income Security Act of 1974, 88 Stat. 832 *et seq.*, 29 U.S.C. (Supp. V) section 1001 *et seq.*; the McCarran-Ferguson Act, 59 Stat. 33 *et seq.*, 15 U.S.C. (Supp. V) section 1011 *et seq.*; the Knox-Keene Health Care Service Plan Act of 1975, California stats. 1975, ch. 941, California Health and Safety Code section 1340 *et seq.;* and Title 10, Calif. Admin. Code, ch. 3, subch. 5.5, section 1300.43 *et seq.;* all of which are reprinted in pertinent part in Appendix C, *infra,* pages 23-47.

STATEMENT PURSUANT TO RULE 33(2)(b)

Since this proceeding draws into question the constitutionality of the Employee Retirement Income Security Act of 1974, 88 Stat. 832, 29 U.S.C. (Supp. V) section 1000 *et*

seq., an Act of Congress affecting the public interest, and neither the United States nor any agency, officer, or employee thereof is a party, it is noted that 28 U.S.C. section 2403 may be applicable.

No court of the United States, as defined by 28 U.S.C. section 451 has, pursuant to 28 U.S.C. 2403, certified to the Attorney General of the United States the fact that the constitutionality of such Act of Congress has been drawn into question.

QUESTIONS PRESENTED

1. Whether the Court of Appeals erred in holding that the regulation of employee welfare benefit plans by the California Knox-Keene Health Care Service Plan Act of 1975 is preempted by the federal Employee Retirement Income Security Act of 1974 (ERISA).

2. Whether the Court of Appeals erred in holding that the preemption by ERISA of a state insurance law which regulates employee welfare benefit plans does not alter, amend, modify, invalidate, impair or supersede the McCarran-Ferguson Act.

3. Whether the Court of Appeals erred in holding that the preemption by ERISA of a state insurance law which regulates employee welfare benefit plans is a valid exercise of Congressional power under the commerce clause, Article 1, section 8, clause 3 of the United States Constitution.

4. Whether the Court of Appeals erred in holding that the power of Congress under the commerce clause of the United States Constitution to preempt a state law which regulates employee welfare benefit plans is not limited by the Tenth Amendment to the United States Constitution.

STATEMENT OF THE CASE

Jurisdiction in the trial court was conferred by section 502(e)(1), 29 U.S.C. (Supp. V) section 1132(e)(1) of ERISA and 28 U.S.C. section 1331 because the case arises under the provisions of ERISA and because the matter in controversy exceeded the sum of $10,000.

Respondents Hewlett-Packard Company, Standard Oil Company of California, The Pacific Lumber Company, and the Pacific Lumber Company Employee Benefit Organization filed the original complaint in this action on July 30, 1976. Subsequently, John Scalone and Freddy Sanchez, as Trustees of the Joint Benefit Trust established by California Processors, Inc. and the California State Council of Cannery and Food Processing Unions (Joint Benefit Trust), Wells Fargo and Company, and Southern California Drug Benefit Fund intervened as plaintiffs. Respondents are employers engaged in interstate commerce, or employee benefit organizations representing employees engaged in interstate commerce, which maintain various employee welfare benefit plans. Hewlett-Packard Company, Wells Fargo and Company, Standard Oil Company of California and Pacific Lumber Company Employee Benefit Organization offer self-funded plans which reimburse 80% or more of the costs of certain health care independently contracted for and incurred by their employees, annuitants, and covered dependents. Joint Benefit Trust and Southern California Drug Benefit Fund are employer-union health and welfare trust funds which maintain comparable plans for employees, annuitants and their dependents in the drug and canning industries, respectively. As alternatives to the self-funded indemnity plans, Southern California Drug Benefit Fund offers Kaiser Health Plan, Inc. and a prepaid dental plan.

Each of these plans is an "employee welfare benefit plan" within the meaning of section 3(1), 29 U.S.C. (Supp. V) 1002(1), of ERISA, and is, therefore subject to regulation under ERISA. Each is also a "health care service plan" within the meaning of the California Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) and is, therefore, unless preempted, subject to California regulation under Knox-Keene.

ERISA was enacted by Congress in 1974 and became operative on January 1, 1975, primarily as a pension reform measure. ERISA regulates employee pension benefit plans (§ 3(2), 29 U.S.C. (Supp. V) 1002(2)) and employee welfare benefit plans (§ 3(1), 29 U.S.C. (Supp. V) 1002(1)). Collectively, both welfare and pension benefit plans are referred to in ERISA as "employee benefit plans". (§ 3(3), 29 U.S.C. (Supp. V) 1002(3)). ERISA regulates employee welfare benefit plans in the areas of disclosure of benefits, reporting to the United States Department of Labor, plan establishment and maintenance requirements, holding of plan assets in trust, fiduciary standards and claims procedure.

Knox-Keene became operative on July 1, 1976 and is legislation enacted under the police power of the State of California to protect the health and well-being of citizens of California. Knox-Keene regulates the provision, arrangement and delivery of health care services by the many various health care service plans operating in California. Knox-Keene was intended to be and is a comprehensive scheme of regulation of the delivery of health care services. Knox-Keene regulates all entities or plans in the areas of funding, disclosure, sales practices and the quality of health care provided. The entities or plans regulated, including self-funded plans and those which directly pro-

vide health care services, provide insurance-type coverage. Knox-Keene requires that all health care service plans be licensed by petitioner, who is charged with the enforcement of the provisions of Knox-Keene.

Based on the supremacy clause of the United States Constitution, respondents sought and obtained on November 30, 1976 from the District Court a declaration that ERISA, and in particular section 514(a) of ERISA, 29 U.S.C. (Supp. V) 1144(a), preempts Knox-Keene insofar as Knox-Keene applies to the employee benefit plans which respondents maintain. In addition, respondents sought and obtained on November 30, 1976, from the District Court a permanent injunction prohibiting the regulation of the employee benefit plans of respondents under Knox-Keene.

Petitioner contends (1) that Knox-Keene is a law of the State of California which regulates insurance and is therefore excepted by section 514(b)(2)(A), 29 U.S.C. (Supp. V) 1144(b)(2)(A), of ERISA from the preemption of section 514(a), 29 U.S.C. (Supp. V) 1144(a), of ERISA; (2) that the preemption of Knox-Keene violates section 514(d), 29 U.S.C. (Supp. V) 1144(d), of ERISA and impairs the McCarran-Ferguson Act; (3) that section 514(a) of ERISA is unconstitutional because it exceeds the powers delegated to Congress under the United States Constitution; and (4) that ERISA infringes on the sovereignty of the States as recognized by the Tenth Amendment to the United States Constitution.

Petitioner appealed to the Court of Appeals from the judgments entered in favor of respondents.

On January 24, 1977 the District Court issued its Memorandum Opinion. *See* Appendix B, pages 7-22.

On March 24, 1978, the Court of Appeals affirmed the holding of the District Court. *See* Appendix A, pages 1-6.

REASONS FOR GRANTING THE WRIT

1. The Court of Appeals Has Decided an Important Question of Federal Law Which Has Not Been, But Should Be, Settled by This Court.

A. CERTIORARI SHOULD BE GRANTED SINCE THE DECISION OF THE COURT OF APPEALS RESULTS IN THE PREEMPTION OF A STATE LAW VITALLY IMPORTANT TO THE HEALTH AND WELFARE OF CITIZENS OF THE STATE OF CALIFORNIA.

The Knox-Keene Act is a comprehensive regulatory scheme regulating all health care service plans which provide, administer, or arrange for the provision of health care services.[2] As such, Knox-Keene is a state law of vital importance to the health and welfare of numerous citizens of the State of California.

Self-funded employee welfare benefit plans, of the type involved in this case, are health care service plans within the meaning of and subject to the provisions of Knox-Keene. The Court of Appeals, however, decided that the regulation of employee welfare benefit plans by Knox-Keene is preempted by ERISA, thus denying persons enrolled in employee welfare benefit plans the protection afforded by Knox-Keene.

As discussed, *infra*, in this section, petitioner contends that ERISA does not reasonably protect plan enrollees from potential abuses by employee welfare benefit plans providing health care services. Consequently, unless this court reviews the decision of the Court of Appeals, a state law vitally important to the welfare of the citizens of the State of California will be displaced by inadequate federal legislation.

The importance of the regulation of self-funded employee welfare benefit plans by Knox-Keene is perhaps best reflected by the large number of California citizens enrolled

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2. Section 1399.5 of Knox-Keene, Cal. Health and Safety Code § 1399.5 (West).

in employee welfare benefit plans, and by the type of protection afforded such persons by Knox-Keene.

Petitioner estimates that 1.5 million California citizens are enrolled in self-funded employee welfare benefit plans, and many of those persons rely exclusively on such plans to provide or pay for all their medical needs.

To protect persons enrolled in all forms of health care service plans, including employee welfare benefit plans, the California Legislature enacted Knox-Keene.

Knox-Keene provides maximum protection for persons enrolled in health care service plans by regulating areas such as funding, disclosure, sales practices, and quality of services.

In particular, Knox-Keene requires that health plans satisfy minimum standards of financial soundness and demonstrate an ability to meet their contractual obligations;[3] that contracts between plans and providers, *e.g.*, doctors and dentists, be in writing and that such contracts "... set forth that in the event the plan fails to pay for health care services ... the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan."[4]

Knox-Keene also requires that plan contracts be fair, reasonable, and consistent with the objectives of the Act,[5] and requires that every plan maintain an agreement with an unrelated subsequent provider to "provide the payment of the cost of the originally contracted health care service or to provide the originally contracted health care service in the event the plan ceases to do business."[6]

3. Sections 1376 and 1377 of Knox-Keene, Cal. Health and Safety Code, §§ 1376 and 1377 (West).

4. Section 1379(a) of Knox-Keene, Cal. Health and Safety Code § 1379(a) (West).

5. Section 1367(h) of Knox-Keene, Cal. Health and Safety Code § 1367(h) (West).

6. Section 1375(a) of Knox-Keene, Cal. Health and Safety Code § 1375(a) (West).

Knox-Keene mandates certain minimum benefits and coverage. For example, Knox-Keene requires the provision of certain basic health care services such as physician, hospital in-patient, diagnostic and therapeutic, home health care, preventive health, and emergency health care services; that immediate coverage be granted to new born infants and adopted minor children; that there be continuing coverage for certain mentally retarded or physically handicapped children; that there be continuing coverage for dependents of employees if the plan provides for coverage of the employee after termination of employment; and that a plan not discriminate against handicapped persons or groups containing handicapped persons.[7]

In contrast to the detailed provisions of Knox-Keene, the only substantive requirements of ERISA with respect to employee welfare benefit plans are those requiring disclosure; the filing of certain reports with the Secretary of Labor; the establishment and maintenance of a plan pursuant to a written instrument; the requirement that plan assets be held in trust; the requirement that plan administrators comply with certain fiduciary standards; and the establishment and compliance with an acceptable claims procedure.[8] ERISA contains no provisions which insure the solvency of a health care plan, or that plan subscribers receive certain minimum benefits.

Consequently, the preemption of Knox-Keene would result in a potentially disastrous reduction in the protection afforded persons enrolled in self-funded employee welfare

7. Sections 1367(i), 1373(c), (d) and (f) of Knox-Keene, Cal. Health and Safety Code §§ 1367(i), 1373 and 1373(c), (d) and (f) (West).

8. Sections 101, 104, 402, 403, 404, and 503 of ERISA, 29 U.S.C. (Supp. V) 1021, 1024, 1102, 1103, 1104 and 1133.

benefit plans in California, and, in any other state with similar legislation.

Where, as here, a decision of the Court of Appeals results in the preemption of an important state law vital to the health and welfare of California residents, certiorari should be granted to determine whether, as petitioner contends, the decision of the Court of Appeals departs from accepted statutory interpretations and constitutional doctrines as discussed, *infra*.

B. THE DECISION OF THE COURT OF APPEALS IS BASED ON A MISCONSTRUCTION OF THE PREEMPTION PROVISIONS OF ERISA WHICH HAVE NOT PREVIOUSLY BEEN CONSTRUED BY THIS COURT.

Section 514(b)(2)(A), 29 U.S.C. (Supp. V) 1144(b)(2)(A), of ERISA expressly excepts from preemption, by section 514(a), 29 U.S.C. (Supp. V) 1144(a), state laws such as Knox-Keene, which regulate insurance. Section 514(b)(2)(A) provides in pertinent part that:

> "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates *insurance*, banking or securities." [Emphasis added.]

Petitioner contends that Knox-Keene is a state law which regulates insurance and is therefore excepted from preemption by section 514(b)(2)(A).

Petitioner's position is consistent with the holding in *Manasen v. California Dental Services*, 424 F.Supp. 657 (N.D. Cal. 1976), *appeals docketed*, No. 77-1751, No. 77-1752 (9th Cir.) wherein the court concluded that Knox-Keene is a state law which regulates the business of insurance.

The Court of Appeals in affirming the District Court, however, decided that Knox-Keene is not excepted from preemption by section 514(b)(2)(A) because of the language contained in section 514(b)(2)(B), 29 U.S.C. (Supp. V) 1144(b)(2)(B), of ERISA. *See* Appendix A, pages 3-6.

Section 514(b)(2)(B) of ERISA provides in pertinent part that:

> "[A]n employee benefit plan . . . shall [not] be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, insurance contracts. . . ."

Petitioner contends that the decision of the Court of Appeals is based on a misconstruction of section 514(b)(2)(B), and that the construction of section 514(b)(2)(B) by the Court of Appeals is inconsistent with a reasonable construction of section 514(b)(2)(A).

The Court of Appeals construed section 514(b)(2)(B) to mean that a state "deems" an employee benefit plan to be engaged in the business of insurance if the state subjects the plan to the provisions of a state insurance law. Such a construction, however, conflicts with section 514(b)(2)(A). Under the construction of section 514(b)(2)(B) by the Court of Appeals, a state may not subject employee benefit plans to its insurance laws. Section 514(b)(2)(A), however, not only assumes the existence of state insurance laws which regulate employee benefit plans but also expressly excepts such laws from preemption.

Furthermore, to construe section 514(b)(2)(B) so that section 514(b)(2)(A) is meaningless would be inconsistent with the decision in *Wadsworth v. Whaland* and *Dawson v. Whaland*,[9] ..... F. Supp. ....., No. 76-266, (D.N.H., filed Feb.

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9. *Dawson v. Whaland* and *Wadsworth v. Whaland* were separate actions in the District Court jointly resolved by cross motions for summary judgment. The opinion (order) of the District Court, Appendix D, was the opinion of the court in both actions. The actions were separately docketed on appeal but were heard together resulting in the opinion of the First Circuit Court of Appeals at 562 F.2d 70 (1977).

28, 1977), *aff'd.*, 562 F.2d 70 (1st Cir. 1977) *cert. denied,* .....U.S..... (1978), 46 USLW 3645 (April 17, 1978, No. 77-765 and No. 77-772, respectively.) The Court of Appeals in *Wadsworth* and *Dawson, supra,* stated:

> "We are unable to accept plaintiffs' contention that the deemer provision [§ 514(b)(2)(B) of ERISA] forbids the states from indirectly affecting employee benefit plans .... In order to accept plaintiffs' construction, we would have to construe section 514 without its savings clause pertaining to state regulation of insurance. This we cannot do; we must interpret the statute as written. Congress was fully aware of the functions and scope of employee benefit plans and, nonetheless, exempted state laws regulating insurance from preemption .... Such a construction would completely emasculate the savings clause. It is our duty when interpreting an act of Congress to construe it in such a manner as to give effect to all its parts and to avoid a construction which would render a provision surplusage." (Citing cases) 562 F.2d at 78.

See also Insurer's Action Council v. Heaton, 423 F.Supp. 921, 926 (D. Minn. 1976).

The Court of Appeals below did not resolve this conflict. Nor did the Court of Appeals attempt to reconcile section 514(b)(2)(A) with section 514(b)(2)(B).

This Court has not previously construed section 514 (b)(2)(A) and section 514(b)(2)(B). Therefore, petitioner contends that certiorari should be granted to reconcile and give full effect to the two sections, and to reconcile any inconsistency between the decision by the Court of Appeals and the decisions in *Wadsworth, supra,* and *Insurer's Action Council, supra.* Certiorari is especially appropriate where, as here, misconstruction of a federal statute by the Court of Appeals results in the preemption of an important

state law vital to the health and welfare of the citizens of the State of California and may also result in the preemption of other state laws similar to Knox-Keene.

C. THE DECISION OF THE COURT OF APPEALS IMPAIRS THE McCARRAN-FERGUSON ACT WHICH RESERVES TO THE STATES THE POWER TO REGULATE THE BUSINESS OF INSURANCE.

Regulation of the business of insurance has been expressly reserved to the individual states by sections 1011 and 1012(a) of the McCarran-Ferguson Act, 59 Stat. 33, 34, as amended, 15 U.S.C. (Supp. V) 1011, 1012(a).

The decision of the Court of Appeals, however, limits the power of the State of California to regulate the business of insurance, contrary to the express language of sections 1011 and 1012 of the McCarran-Ferguson Act. *See* Appendix pages 23-24.

Section 1011 of the McCarran-Ferguson Act provides in pertinent part that:

> "Congress declares that the continued regulation ... *by the several States* of the business of insurance is in the public interest ...." [Emphasis added.]

In addition, section 1012 of McCarran-Ferguson Act provides in pertinent part that:

> "(a) the business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation ... of such business.
>
> "(b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance ... *unless such Act specifically relates to the business of insurance* ...." [Emphasis added.]

To insure that federal legislation, such as the McCarran-Ferguson Act, would not be impaired by ERISA, Congress enacted section 514(d), 29 U.S.C. (Supp. V) 1144(d), of ERISA. Section 514(d) provides in pertinent part that:

"(d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, *impair* or supersede *any law of the United States* . . . ." [Emphasis added.]

Petitioner contends that, despite the prohibitory language of section 514(d), the Court of Appeals construed ERISA in a manner which results in the impairment of the McCarran-Ferguson Act.

The Court of Appeals held that the preemption of a state law, such as Knox-Keene, which regulates the business of insurance,[10] does not impair the McCarran-Ferguson Act because ERISA "specifically relates to" the business of insurance within the meaning of section 1012(b) of the McCarran-Ferguson Act. *See* Appendix A, pages 5-6.

The Court of Appeals also held, without further explanation, that the preemption of state laws regulating the business of insurance does not impair the McCarran-Ferguson Act because of the "deeming" language of section 514(b)(2)(B) of ERISA. *See* Appendix A, pages 5-6.

Petitioner contends that the Court of Appeals erred in its finding that ERISA "specifically relates to" the business of insurance within the meaning and intent of section 1012(b) of the McCarran-Ferguson Act. Petitioner's contention is supported by *dicta* in *Dawson v. Whaland, supra,* wherein the District Court stated that:

"ERISA is not primarily concerned with the regulation of insurance. ERISA is a broad act, the parts of which are important . . . deal almost exclusively with reporting provisions to ensure the financial health of employee benefit trusts. The remainder of ERISA deals mostly with tax aspects of retirement funds, contributions to them, and payments from them. Even

10. The Court of Appeals assumed, *arguendo,* that Knox-Keene is a state law regulating insurance. *See* Appendix A, page 5.

without the exception for insurance regulation at 29 U.S.C. § 1144(b)(2)(A), the effect of 15 U.S.C. § 1012 [of the McCarran-Ferguson Act] is to except insurance regulation from preemption. The exception makes the intent not to preempt clearer." *See* Appendix D, pages 48-58 at 58.

See also Hamilton Life Ins. Co. v. Republic National Life Ins. Co., 291 F.Supp. 225, 230 (1968), *aff'd.,* 408 F.2d 606 (1969).

The fact that ERISA may in a very small number of sections *refer* to the term "insurance" or phrases containing the word "insurance" in them does not mean that ERISA "specifically *relates* to" the business of insurance, as intended by the McCarran-Ferguson Act.

Petitioner also contends that the Court of Appeals misconstrued section 514(b)(2)(B) of ERISA. (*See* Part 1.B. of this Petition, *supra.*)

This case presents questions of first impression involving the construction of ERISA, the possible impairment of the McCarran-Ferguson Act by ERISA, and the preemption of Knox-Keene, an important California law. In particular, this case presents this Court with an opportunity to provide a definititive and necessary construction of section 514(b)(2)(B) of ERISA, and to determine whether ERISA specifically relates to the business of insurance.

Therefore, petitioner contends that certiorari should be granted to decide these important federal questions.

2. The Decision of the Court of Appeals Conflicts With Prior Decisions of This Court Construing the Scope of Congress' Power Under the Commerce Clause.

Congress enacted ERISA pursuant to its express authority to regulate commerce under Article I, section 8, clause 3 of the United States Constitution.

In holding that Knox-Keene is preempted by ERISA, the Court of Appeals determined that the passage of ERISA was a valid exercise of Congress' power under the commerce clause. The decision of the Court of Appeals, however, conflicts with prior decisions of this Court which have construed the scope of Congress' power under the commerce clause.

In an unbroken line of decisions since *McCulloch v. Maryland,* 17 U.S. (4 Wheat.) 316, 421 (1819), this Court has enunciated a two-part test for determining whether a particular law is a valid exercise of Congress' power under the commerce clause.

The test, as recently stated by this Court in *National League of Cities v. Usery,* 426 U.S. 833, 840 (1976) quoting *Heart of Atlanta Motel v. United States,* 379 U.S. 241, 262 (1964), is that "'The means chosen by [Congress] must be reasonably adapted to the end permitted by the Constitution.'"

Petitioner contends that the decision of the Court of Appeals conflicts with the test set forth in *National League of Cities, supra,* in that the decision of the Court of Appeals is based on an erroneous determination that the means chosen by Congress is reasonably adapted to a legitimate end.

The end Congress sought to achieve in its regulation of employee welfare benefit plans is set forth in section 2 of ERISA, 29 U.S.C. (Supp. V) 1001, which provides as follows:

> "[I]t is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided *assuring the equitable character of such plans and their financial soundness.*" (Emphasis added.)

Petitioner concedes that the end stated by Congress in section 2 of ERISA is a legitimate end permitted by the Constitution.

Petitioner contends, however, that the means chosen by Congress is not reasonably adapted to the end of providing minimum standards to assure the "equitable character" and "financial soundness" of employee welfare benefit plans.

ERISA contains no provisions regulating the type of benefits plan members are entitled to receive and expressly exempts employee welfare benefit plans from the minimum funding standards set forth in section 211 *et seq.,* 29 U.S.C. (Supp. V) 1081 *et seq.,* of ERISA. ERISA, therefore, is a regulatory scheme which is unsuited and inadequate to assure the "equitable character" or "financial soundness" of employee welfare benefit plans. Knox-Keene, however, contains numerous provisions insuring the fairness of health care service plans and specifically establishes standards of financial soundness by requiring that all health care service plans licensed under Knox-Keene have and maintain a certain minimum tangible net equity. 10 Cal. Admin. Code §§ 1300.75 *et seq.* Therefore, the preemption of Knox-Keene defeats rather than accomplishes the stated "end" of ERISA to assure the "equitable character" and "financial soundness" of employee welfare benefit plans. Thus, section 514(a), 29 U.S.C. (Supp. V) 1144(a), of ERISA is an unconstitutional exercise of the commerce power.

Petitioner contends that the test set forth in *National League of Cities v. Usery, supra,* imposes an obligation on Congress to enact legislation which reasonably accomplishes the end sought to be achieved. Furthermore, where, as here, part of the means chosen by Congress is the total preemption of an important state law, which regulates in an area of traditional state regulation under the police

power, the means chosen by Congress should be even more closely scrutinized.

The Court of Appeals erred in its failure to closely scrutinize the means chosen by Congress in ERISA, and also erred in its failure to determine whether the means chosen reasonably accomplishes the stated goals of Congress in enacting ERISA. As a result, the decision of the Court of Appeals is based on a misconception of the scope of Congress' power under the commerce clause, and conflicts with prior decisions of this Court.

Since the error of the Court of Appeals results in the total preemption of an important California state law, *i.e.*, Knox-Keene, and since the decision of the Court of Appeals also affects every other state desirous of enacting similar legislation, petitioner urges this Court to grant certiorari to conform the decision of the Court of Appeals to the prior decisions of this Court.

3. The Decision of the Court of Appeals Involves an Important and Novel Constitutional Question Regarding the Limitations Imposed on Congress by the Tenth Amendment to the United States Constitution.

By holding that Knox-Keene is preempted by ERISA, the Court of Appeals failed to fully recognize the limitations imposed on Congress by the Tenth Amendment to the United States Constitution.

This Court has previously recognized that there are limits upon the power of Congress to override state sovereignty, even when Congress is exercising its otherwise plenary powers to regulate commerce which are conferred by Article I of the United States Constitution. *National League of Cities v. Usery, supra.*

In *Fry v. United States,* 421 U.S. 542 (1975), this Court recognized that an express declaration of this limitation is found in the Tenth Amendment:

> "While the Tenth Amendment has been, characterized as a 'truism', stating merely that 'all is retained which has not been surrendered', *United States v. Darby,* 312 U.S. 100, 124 (1941), it is not without significance. The Amendment expressly declares the constitutional policy that Congress may not exercise power in a fashion that impairs the States' integrity or their ability to function effectively in a federal system." 421 U.S. at 547, n. 7.

Subsequently, in *National League of Cities v. Usery, supra,* this Court relied on the Tenth Amendment to declare unconstitutional the 1974 amendments to the Fair Labor Standards Act,[11] which extended the wage and hour provisions of the Fair Labor Standards Act to almost all public employees employed by the States and by their various political subdivisions.

In *National League of Cities v. Usery, supra,* this Court held that Congress may not, consistent with the Tenth Amendment, pass legislation directed against the States *qua* States if such legislation "[D]isplace[s] the States' freedom to structure integral operations in areas of traditional governmental functions . . . ." 426 U.S. at 852.

The decision in *National League of Cities v. Usery, supra,* however, leaves unanswered the question of whether the Tenth Amendment may, under certain circumstanecs, also prohibit Congress from passing legislation not expressly directed against the States *qua* States, but which neverthe-

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11. The Fair Labor Standards Act of 1934, 52 Stat. 1060, 29 U.S.C. § 201 *et seq.* (1940 ed.), as amended by 88 Stat. 55, 29 U.S.C. § 201 *et seq.* (1970 ed., Supp. IV).

less materially affects the sovereignty and integrity of the States in an area of traditional state governmental regulation.

As Justice Brennan commented in his dissenting opinion in *National League of Cities v. Usery, supra:*

> "Certainly the paradigm of sovereign action—action *qua* State—is in the enactment and enforcement of state laws. *Is it possible that my Brethren are signaling abandonment of the heretofore unchallenged principle that Congress 'can, if it chooses, entirely displace the States to the full extent of the far-reaching Commerce Clause'? Bethlehem Steel Co. v. New York State Board,* 330 U.S. 767, 780 (1947) (opinion of Frankfurter, J.). Indeed, that principle sometimes invalidates state laws regulating subject matter of national importance even when Congress has been silent. *Gibbons v. Ogden,* 9 Wheat, 1 (1824); see *Sanitary District v. United States,* 266 U.S. at 426. In either case the ouster of state laws obviously curtails or prohibits the States' prerogatives to make policy choices respecting subjects clearly of greater significance to the 'State *qua* State' than the minimum wage paid to the state employees. The Supremacy Clause dictates this result under 'the federal system of government embodied in the Constitution.' *Ante,* at 852." (Emphasis added.) 426 U.S. at 875.

The case presented by this Petition is precisely the type of case to which Justice Brennan referred, and provides this Court with the opportunity to decide whether the power of Congress to regulate private entities under the commerce clause is limited, under certain circumstances, by the Tenth Amendment. ERISA, although not directed against the States *qua* States, severely impairs the police power of the States in a vital area of traditional state

governmental regulation, *i.e.,* health care, and does so *without* replacing the state law with comparable or reasonably adequate federal legislation. (*See* Part 1.A. of this Petition which discusses the importance of Knox-Keene and the failure of ERISA to provide reasonable protection for persons enrolled in self-funded employee welfare benefit plans.) Such an effect impairs the integrity and sovereignty of the State of California and impairs the ability of the State of California to function effectively in the federal system in violation of the Tenth Amendment.

Petitioner contends that where, as here, the preempting federal legislation in question does not reasonably provide the protection to residents of the State of California afforded by Knox-Keene, preemption of Knox-Keene would be in violation of the Tenth Amendment and contrary to the principles enunciated in *National League of Cities v. Usery, supra.*

Since this important constitutional question has not previously been decided by this Court, the writ of certiorari sought by petitioner should be granted.

CONCLUSION

For all the reasons stated herein, a writ of certiorari should issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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Appendix A

United States Court of Appeals
for the Ninth Circuit

FILED MAR. 14, 1978
EMIL E. MELFI, JR.
Clerk, U.S. Court of Appeals
(Entered March 14, 1978)

No. 77-1564

OPINION

HEWLETT-PACKARD COMPANY, a California corporation, et al.,
Plaintiffs-Appellees,
v.
WILLIE R. BARNES, Commissioner of Corporations of the State of California,
Defendant-Appellant,
JOHN SCALONE and FREDDY SANCHEZ, Trustees of the Joint Benefit Trust Established by California Processors, Inc., and the California State Council of Cannery and Food Processing Unions, et al.,
Plaintiffs-Intervenors.

Appeal from the United States District Court
for the Northern District of California

Before: BROWNING and HUFSTEDLER, Circuit Judges, and BONSAL*, District Judge

*Honorable Dudley B. Bonsal, Senior United States District Judge, Southern District of New York, sitting by designation.

PER CURIAM:

Willie R. Barnes, California Commissioner of Corporations, appeals from a district court judgment permanently enjoining him from enforcing California's Knox-Keene Health Care Service Plan Act of 1975, Cal. Health & Safety Code §§ 1340-1399.5 (West Supp. 1977) ("Knox-Keene") with respect to appellees' employee benefit plans regulated by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1381 (Supp. V 1975) ("ERISA"). The district court found that section 514 of ERISA expressly and validly preempts state regulation of ERISA-covered employee benefit plans. Appellant contends: (1) that section 514(a) of ERISA[1] was not intended to preempt Knox-Keene; (2) that Knox-Keene is a state insurance law exempted by section 514(b)[2] from ERISA's otherwise broad

1. 29 U.S.C. § 1144(a) (Supp. V 1975):
   Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

2. 29 U.S.C. § 1144(b) (Supp. V 1975):
   (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.
   (2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
   (B) Neither an employee benefit plan desecribed in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

preemption; (3) that ERISA is unconstitutional if construed to preempt Knox-Keene; and (4) that preemption would impair other federal legislation in violation of section 514(d).[3]

As to the first three issues, we affirm on the grounds relied upon by Judge Renfrew in his well considered opinion below. *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977).[4] The clear wording of section 514 and the relevant legislative history show that Congress unmistakably intended ERISA to preempt a state law such as Knox-Keene that directly regulates employee benefit plans. *Id.* at 1297-1300. Although section 514(b)(2)(A) exempts from preemption state regulation of insurance, section 514(b)(2)(B) provides that employee benefit plans may not be

3. 29 U.S.C. § 1144(d) (Supp. V 1975):
   Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

4. Although Judge Renfrew examined the legislative history and found support there for the conclusion that ERISA preempts Knox-Keene's regulation of employee benefit plans, he alternatively relied on the "plain-meaning" rule of statutory construction foreclosing an inquiry into legislative history where the language of a statute unequivocally expresses its meaning. *See* 425 F. Supp. at 1297.
   The Supreme Court, however, recently expressed dissatisfaction with the "plain-meaning" rule: "When aid to construction of the meaning of words, as used in the statute, is available, there certainly can be no 'rule of law' which forbids its use, however clear the words may appear on 'superficial examination.'" Train v. Colorado Public Interest Research Group, Inc., 426 U.S. 1, 10 (1976) (quoting United States v. American Trucking Assn's, 310 U.S. 534, 543-44 (1940).
   We therefore look to Judge Renfrew's legislative history analysis alone and conclude that he has amply demonstrated that Congress unmistakably intended ERISA broadly to preempt state regulations of ERISA-regulated employee benefit plans. *See* 425 F. Supp. at 1298-1300.

considered to be in the business of insurance for purposes of the exception to preemption. *Id.* at 1300. Preemption of state law by ERISA is a valid exercise of Congress's commerce power and does not violate the tenth amendment. *Id.* at 1300-01.

We need discuss only the fourth issue raised by appellant—that preemption of Knox-Keene would impair other federal legislation in violation of ERISA's section 514(d), 29 U.S.C. § 1144(d) (Supp. V. 1975), which provides in relevant part:

> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law.

Appellant claims that, by preempting Knox-Keene, ERISA impairs both the Health Maintenance Organization Act, 42 U.S.C. §§ 300e - 300e-15 (Supp. V 1975) ("HMO Act"), and the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1970).

The HMO Act regulates private health care providers but not employee benefit plans that do not directly provide health care services. The Act anticipates concurrent state regulation. Appellant argues that Knox-Keene is California's regulatory scheme for HMOs and that if ERISA preempts Knox-Keene, the HMO Act will be impaired.

The error in the argument is that ERISA only preempts Knox-Keene as applied to employee benefit plans, and there is nothing to indicate that any HMO is an employee benefit plan. Appellant suggests that some HMOs may in the future "transform" into employee benefit plans to avoid state regulation, but fails to point out any example of such

"transformation," or, for that matter, any specific conflict between ERISA and the HMO Act. We decline to upset ERISA's preemptive clause on such hypothetical grounds.

Appellant makes a similar contention with regard to the McCarran-Ferguson Act which provides in part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . .

15 U.S.C. § 1012(b) (1970). Under McCarran-Ferguson, ERISA should not be construed in a way that violates the policy of reserving to the states the power to regulate insurance unless ERISA "specifically relates" to insurance. Appellant claims that Knox-Keene is a state law regulating insurance and that construing ERISA to preempt Knox-Keene violates the McCarran-Ferguson Act because ERISA does not "specifically relate" to insurance.

Assuming arguendo that Knox-Keene is a state law regulating insurance, to the extent that ERISA clashes with McCarran-Ferguson by impairing Knox-Keene, appellant's argument not only ignores those ERISA sections that undeniably "specifically relate" to the business of insurance, but also overlooks ERISA's "deemer" clause, which states that an employee benefit plan shall not be deemed to be engaged in the business of insurance for the purposes of state law. 29 U.S.C. § 1144(b)(2)(B) (Supp. V. 1975). *See also id.* §§ 1002(17), 1081(a)(2), 1081(b), 1101(b)(2), 1323. If McCarran-Ferguson applies, therefore, ERISA falls within the clause excepting federal laws that "specifically

relate" to the business of insurance.[5] *Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 416 F. Supp. 316, 320 n.1 (N.D. Ind. 1977), *aff'd on other grounds*, No. 77-1281 (7th Cir. Nov. 8, 1977). *Cf. Wadsworth v. Whaland*, 562 F.2d 70, 77-78 (1st Cir. 1977) (state may not directly regulate employee benefit plan under general insurance law despite McCarran-Ferguson).

We hold that ERISA preempts California's Knox-Keene Act to the extent that Knox-Keene seeks to regulate ERISA-covered employee benefit plans. If California desires to regulate such employee benefit plans as part of its comprehensive health care service legislation, that California must ask Congress to make appropriate changes in ERISA.

The judgment of the district court is affirmed.

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5. Insurers' Action Council, Inc. v. Heaton, 423 F. Supp. 921 (D. Minn. 1976) is the only case that suggests the opposite conclusion. The *Insurers' Action Council* court denied plaintiff insurance companies' motion for a preliminary injunction against enforcement of the Minnesota Comprehensive Insurance Act of 1976. The procedural posture of the case—motion for preliminary injunction—and the court's conclusion only that "the ultimate success of plaintiffs' preemption claim is questionable at best," *id.* at 926, militate against according the decision great weight.

Appendix B

ORIGINAL FILED JAN. 24, 1977
CLERK, U.S. DIST. COURT
SAN FRANCISCO

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

No. C-76-1607-CBR

MEMORANDUM OF OPINION

HEWLETT-PACKARD COMPANY, a California corporation, et al.,
Plaintiffs,

vs.

WILLIE R. BARNES, Commissioner of Corporations of the State of California,
Defendant.

JOHN SCALONE and FREDDY SANCHEZ, etc., et al.,
Plaintiff in Intervention.

SOUTHERN CALIFORNIA DRUG BENEFIT FUND,
Plaintiff in Intervention.

WELLS FARGO AND COMPANY,
Plaintiff in Intervention.

Plaintiffs commenced this action to prevent defendant Willie R. Barnes, Commissioner of Corporations of the State of California, from requiring them to comply with the California Knox-Keene Health Care Service Plan Act of 1975, Cal.Health & Safety Code § 1340, *et seq.* ("Knox-Keene"). Plaintiffs Standard Oil Company of California ("Standard") Hewlett-Packard Company ("Hewlett-Packard"), The Pacific Lumber Company ("Pacific"), and

The Pacific Lumber Company Employee Benefits Organization ("Pacific Employee Organization") filed the original complaint in this action on July 30, 1976. Pursuant to stipulation among plaintiffs, defendant, and intervenors, John Scalone and Freddy Sanchez as Trustees of the Joint Benefit Trust established by California Processors, Inc., and the California State Council of Cannery and Food Processing Unions ("Joint Benefit Trust") and Wells Fargo and Company ("Wells Fargo") were permitted to intervene as plaintiffs on September 1, 1976. In addition, on September 26, 1976, the Court granted the motion of Southern California Drug Benefit Fund ("Benefit Fund") to intervene as plaintiff.

The original and intervening plaintiffs are employers engaged in commerce or employee benefit organizations representing employees engaged in commerce which maintain various employee health benefit plans. Standard, Hewlett-Packard, and Wells Fargo offer self-funded plans which reimburse 80% or more of certain health care expenses independently contracted for and incurred by their employees, annuitants, and covered dependents in California and other states.[1] Pacific Employee Organization, a nonprofit Delaware corporation, maintains similar benefit plans for the employees and annuitants of Pacific and their covered dependents.[2] Joint Benefit Trust and Benefit Fund, employer-union health and welfare trust funds, maintain comparable plans for employees and annuitants in the drug and canning industries, respectively, and their

1. Affidavit of Robert K. Maggy, Manager of the Benefits Division of Standard's Personnel Department, executed July 29, 1976; Affiidavit of Ray L. Wilbur, Vice President in Charge of Human Resources and Development of Hewlett-Packard, executed July 30, 1976; Affidavit of George Innes, Assistant Vice President of Wells Fargo, executed August 31, 1976.

2. Affidavit of Gene G. Elam, Vice President of Finance of Pacific, executed July 27, 1976.

dependents.[3] In addition, as alternatives to the self-funded indemnity plans, Benefit Fund offers its participants the option of participating in Kaiser Health Plan, Inc., for hospital, medical and surgical care, and in a prepaid dental plan which it has arranged with contracting doctors.[4]

Each of these plans is concededly an "employee welfare benefit plan" within the meaning of Section 3 of the Employee Retirement Income Security Act of 1974 ("ERISA"),[5] 29 U.S.C. § 1003(a), and is therefore subject to regulation under that act.[6] Each is also admittedly a

3. Affidavit of Peter Morse, Director of Administrative Procedure for United States Administrators of Beverly Hills, California (which administers Joint Benefit Trust), executed August 27, 1976; Affidavit of David L. Mauss, Associate Administrator of Southern California Retail Clerks Union and Drug and General Sales Employer Trust Fund, executed October 15, 1976.

4. Affidavit of David L. Mauss, *supra*, n. 3.

5. Pub.L. No. 93-406, 88 Stat. 829 (codified at 29 U.S.C. § 1001, *et seq.* (Supp. IV, 1974)).

6. With exceptions not relevant here, ERISA applies to
"any employee benefit plan if it is established or maintained—
"(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or
"(2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or
"(3) by both." 29 U.S.C. § 1003(a).

29 U.S.C. § 1002(3) defines "employee benefit plan" to include "employee welfare benefit plan" which is in turn defined as
"any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions)." 29 U.S.C. § 1002(1).

"health care service plan" within the meaning of Article One of Knox-Keene[7] and, according to defendant, is subject to regulation under the state statute. Invoking the supremacy clause of the federal Constitution,[8] plaintiffs seek a declaration that ERISA preempts Knox-Keene insofar as Knox-Keene applies to the benefit plans which they maintain, and a permanent injunction prohibiting the regulation of these plans under the state statute.

Defendant contends that ERISA does not preempt Knox-Keene with respect to plaintiffs' plans for two reasons. First, he contends that neither the language of ERISA's preemption clause, Section 514(a) of ERISA, 29 U.S.C. § 1144(a), nor the statute's legislative history unmistakably mandates preemption of state legislation regulating health services such as Knox-Keene. Second, he asserts that Knox-Keene is a state law regulating insurance and thus expressly excluded from preemption under Section 514(b)(2) of ERISA, 29 U.S.C. § 1144(b)(2)(A). In addition, he argues that, if ERISA had so broadly preempted state regulation of health care services, Section 514(a) of the Act is unconstitutional as violative of the Tenth Amendment to the federal Constitution.

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7. Cal.Health & Safety Code § 1345(f) defines a "health care service plan" as "any person who undertakes to arrange for the provision of health care services, including basic health care services, to subscribers or enrollees, or to pay for or to reimburse any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees, and who does not substantially indemnify subscribers or enrollees for the cost of provided services."

8. The United States Constitution, art. 6, cl. 2, provides, in relevant part:

> "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land • • •."

On September 30, 1976, the Court ordered a consolidation of the hearing on plaintiffs' motions for a preliminary injunction and the trial on the merits, pursuant to Rule 65(a)(2) of the Federal Rules of Civil Procedure. Between October 20 and 26, 1976, each of the plaintiffs filed motions for summary judgment. Defendant likewise filed a motion for summary judgment on November 19, 1976. The Court held a consolidated hearing on November 30, 1976. Having heard extensive oral argument and fully considered the parties' written submissions, the Court issued from the bench a declaratory judgment that ERISA preempts the state's regulation of plaintiffs' employee benefit plans under Knox-Keene and a permanent injunction against the enforcement of Knox-Keene as to these plans.[9] However, given the importance and relative novelty of the question, the Court felt that a written discussion of its rationale for the decision would be appropriate.

ERISA is a broad-based legislative scheme designed to protect interstate commerce, the federal taxing power, and the interests of participants in private employee benefit plans and their beneficiaries. Congress sought to accomplish these goals by requiring disclosure and reporting to plan participants; by establishing standards of conduct, responsibility and obligation for fiduciaries of such plans; by providing appropriate remedies, sanctions, and ready access to the federal courts; and by improving the equitable character and soundness of such plans. 29 U.S.C. § 1001(b)(c).

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9. This action was commenced on July 30, 1976, prior to the effective date of The Three Judge Court Amendments, Pub.L. No. 94-381, Aug. 12, 1976. However, even under prior law, three judge courts were not required in supremacy clause cases involving only federal-state statutory conflicts, such as the instant case. *Swift & Co. v. Wickham*, 382 U.S. 111 (1965).

Effective since July 1, 1976, Knox-Keene governs the delivery of health care services to California residents who participate in health care service plans. In enacting Knox-Keene, the California legislature intended to promote the delivery of low cost, quality health care through financially sound plans to participants well informed of the benefits of various available plans. Cal.Health & Safety Code § 1342. Knox-Keene regulates such areas as funding, disclosure, sales practices, and quality of services, and requires that any such plan be licensed by the state Commissioner of Corporations. Although primarily concerned with entities, plans, or contracts which directly deliver health care services, the statute seeks to regulate as well those which provide insurance-type coverage, including self-funded plans such as those maintained by plaintiffs.

When Congress exercises a granted power in a field which states have traditionally occupied, and unmistakably evinces its intent to exclude states from exerting their police power in that field, the federal legislation may displace state law under the Supremacy Clause. *See Florida Lime & Avocado Growers, Inc. v. Paul,* 373 U.S. 132, 142, 146-147 (1963); *Rice v. Santa Fe Elevator Corp.,* 331 U.S. 218, 229-231 (1947).

Section 514(a) of ERISA, 29 U.S.C. § 1144(a), provides:

> "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975."

Although defendant finds the phrase "relate to" "vague and ambiguous,"[10] the Court doubts that Congress could have chosen any more precise language to express its intent to preempt a state statute such as Knox-Keene insofar as it seeks to regulate ERISA-covered employee benefit plans such as those maintained by plaintiffs.[11]

Where the language of a statute unequivocally expresses its meaning, courts do not face the questions of interpretation which warrant a search of legislative history. *Caminetti v. United States,* 242 U.S. 470, 485 (1917). However, as an examination of the legislative history dispels any doubt as to the provision's meaning, a brief discussion may be instructive.

The history of ERISA indicates that Congress, while attempting to formulate legislation concerning employee benefit plans, devoted considerable attention to the question of preemption. Over a period of years, Congress heard testimony from a number of individuals who held widely divergent views on the proper scope of federal preemption

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10. Defendant suggests that, if broadly construed, the language of the preemption clause might be interpreted to mandate the supersession of state regulation of organizations which provide and professionals who render health care service on the theory that such regulation "relate[s] to" employee benefit plans. Whether or not such an interpretation would, in any of the many contexts in which it might arise, comport with the language, history and purpose of ERISA is not for this Court to decide. Neither the outer boundaries of ERISA's preemption provision, nor the permissibility of Knox-Keene's regulation of health care providers, are issues before the Court in this action.

11. The Court's decision ought not surprise the defendant as it is consistent with legal advice offered the state prior to and during the pendency of this suit. In a letter to the Commissioner of Corporations, dated July 14, 1976, James D. Hutchinson, Administrator of Pension and Welfare Benefit Programs for the United States Department of Labor, stated his belief that Knox-Keene could not be applied to employee welfare benefit plans subject to ERISA. Peter Melnicove, Deputy Legislative Counsel of the State of California, expressed a similar opinion in a letter to State Senator Alfred E. Song, dated October 25, 1976.

in the area.[12] While both houses favored preemption of some variety, the House and Senate originally outlined its scope somewhat differently. The House version of H.R. 2, 93d Cong., 1st Sess. (1973), the bill from which ERISA derives, generally limited the scope of preemption to state regulation of areas expressly covered by the bill; *i.e.*, reporting, disclosure, and fiduciary duties with respect to employee benefit plans. In addition, it specifically preempted state regulation involving funding, financing, and forfeitability of such plans.[13] Somewhat more ambiguously,

12. *E.g., compare* Statement of Andrew J. Biemiller, Director, Department of Legislation, AFL-CIO, Hearings on H.R. 5741 (Proposed Welfare and Pension Plan Protection Act) before the General Subcom. on Labor of the House Comm. on Education and Labor, 90th Cong., 2d Sess., at 186 (1968), *and* Statement by Preston C. Basset on behalf of Towers, Perrin, Forster & Crosby, Inc., Hearings on H.R. 2 and H.R. 462 (Proposed Revisions of the Welfare and Pension Plans Disclosure Act) before the General Subcom. on Labor of the House Comm. on Education and Labor, 93d Cong., 1st Sess., pt. 1, at 315 (1973) *and* Statement of Lauren Upson, Member, California Banker's Association Committee on Employee Benefit Trusts. Hearings on H.R. 2 and H.R. 462, *supra*, pt. 2, at 651 (each urging a broad preemption provision to ensure the protection of plan participants and to avoid chaotic dual regulation) *with* Statement of Robert D. Haase, Commissioner of Insurance, State of Wisconsin, Hearing on H.R. 5741, *supra*, at 338 *and* Statement of John P. Thompson for The Southland Corporation, Hearings on H.R. 2 and H.R. 462, *supra*, pt. 1, at 554-555 *and* Statement of Stanley C. DuRose, Jr., Commissioner of Insurance of the State of Wisconsin, Hearings on H.R. 2 and H.R. 462, *supra*, pt. 2 at 188-195 (each urging legislation that would allow for cooperative federal and state regulation).

13. Instead of the language of Section 514(a) of ERISA, the version of H.R. 2 enacted by the House on February 28, 1974, provided:

> "Sec. 514. (a) It is hereby declared to be the express intent of Congress that, except for actions authorized by section 503(e)(1)(B) of this Act and except as provided in subsection (b) of this section the provisions of part 1 of this subtitle shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan to which part 1 applies.
>
> • • • • •

the Senate version of H.R. 2 preempted state law insofar as it "relate[s] to subject matters regulated by this Act or the Welfare and Pension Disclosure Act • • •."[14]

The more sweeping and precise language of Section 514 of ERISA was developed in conference committee. The Conference Report indicates that the committee intended preemption just as broad as the statutory language suggests:

> "Under the substitute, the provisions of title I are to supersede all State laws that relate to any employee benefit plan that is established by an employer engaged in or affecting interstate commerce or by an employee organization that represents employees engaged in or affecting interstate commerce. (However, following title I generally, preemption will not apply to government plans, church plans not electing under the vesting, etc., provisions, workmen's compensation

"(C) It is hereby declared to be the express intent of Congress that the provisions of parts 2, 3, and 4 of this subtitle shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the nonforfeitability of participant's benefits in employee benefit plans described in section 201(a) or 301(a), the funding requirements for such plans, the adequacy of financing of such plans, portability requirements for such plans, or the insurance of pension benefits under such plans." 120 Cong. Rec. 4742 (1974).

14. Instead of the language of Section 514(a) of ERISA, the version of H.R. 2 enacted by the Senate on March 4, 1974, provided:

> "Sec. 699. RELATIONSHIP TO STATE LAWS
>
> "(a) PRE-EMPTION OF STATE LAWS.—It is hereby declared to be the express intent of Congress that, except for actions authorized by section 694 of this title, the provisions of this Act or the Welfare and Pension Plans Disclosure Act shall supersede any and all laws of the States and of political subdivisions thereof insofar as they may now or hereafter relate to the subject matters regulated by this Act or the Welfare and Pension Plans Disclosure Act • • •." 120 Cong. Rec. 5002 (1974).

plans, non-U.S. plans primarily for nonresident aliens, and so-called 'excess benefit plans.')" S.R. 93-1090, 93d Cong., 2d Sess. 383 (1974).

Statements made in the House and Senate debates which preceded the enactment of the conference committee's version of the bill demonstrate that Congress both comprehended the change and intended the statute to occupy the entire field of employee benefit plan regulation. Senator Harrison Williams, Jr., Chairman of the Senate Committee on Labor and Public Welfare, emphasized the broad scope of Section 514:

> "It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumenality thereof, which have the force or effect of law." 120 Cong.Rec. 29933 (1974).

Similarly, Congressman John Dent, Chairman of the Subcommittee on Labor of the House Labor and Education Committee, explained:

> "Finally I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.
>
> • • • • •
>
> "The conferees, with the narrow exceptions specifically enumerated, applied this principle in its broadest sense to foreclose any non-Federal regulation

> of employee benefit plans. Thus, the provisions of section 514 would reach any rule, regulation, practice or decision of any State, subdivision thereof or any agency or instrumentality thereof—including any professional society or association operating under color of law—which would affect any employee benefit plan as described in section 4(a) and not exempt under section 4(b)." 120 Cong.Rec. 29197 (1974).

Finally, Senator Jacob Javits, the ranking minority member of the Senate Committee on Labor and Public Welfare, stressed the intentional replacement of a limited preemption provision with the more comprehensive language of Section 514(2):

> "Both House and Senate bills provided for preemption of State law, but—with one major exception appearing in the House bill—defined the perimeters of preemption in relation to the areas regulated by the bill. Such a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially confiicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme.
>
> "Although the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs. The conferees—recognizing the dimensions of such a policy—also agreed to assign the Congressional Pension Task Force the responsibility of studying and evaluating preemption in con-

nection with State authorities and reporting its findings to the Congress. If it is determined that the preemption policy devised has the effect of precluding essential legislation at either the State or Federal level, appropriate modifications can be made." 120 Cong.Rec. 29942 (1974).

Overall, the legislative history reveals both that Congress carefully considered the question of preemption, including the feasibility of enacting a more limited preemption provision, and that Congress ultimately enacted Section 514(a) with the express purpose of summarily preempting state regulation of ERISA-covered employee benefit plans. That the statute, standing alone or buttressed by its legislative history, was intended to supersede state regulation of benefit plans such as plaintiffs' is indisputable.

Assuming that Section 514(a) would otherwise dictate preemption in this case, defendant argues that Knox-Keene is a state law which regulates insurance, expressly excluded from preemption under Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A). Section 514(b)(2)(A) states:

> "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

Examining both Knox-Keene's definition of a "health care service plan"[15] and the statutory scheme as a whole, and demonstrating in some detail that the statute seeks to oversee plans which possess the risk-transferral and spreading functions endemic to insurance through modes of regulation characteristic of insurance law, defendant

15. See n. 7, *supra*.

concludes that Knox-Keene, as it relates to plaintiffs' benefit plans, is a state law regulating insurance within the meaning of Section 514(b)(2)(A).

Defendant's reasoning might be more persuasive had Congress not specifically precluded a state's ability to classify an employee benefit plan "insurance" and thus escape preemption. Section 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B), states:

> "Neither an employee benefit plan described in section 1003(a) or this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."

The fact that the state considers employee benefit plans to be a unique variety of insurance arrangement, and subjects them to specialized regulation under Knox-Keene rather than generalized regulation under the entire panoply of law addressed to traditional insurers, makes no difference under ERISA. In seeking to regulate plantiffs' plans pursuant to Knox-Keene under the theory that the statute applies to and that such plans constitute "insurance," defendant contravenes the clear intent of Section 514(a) and (b) of ERISA that employee benefit plans, so dubbed or under any other name, be free of state regulation.

Finally, defendant argues that ERISA is an unconstitutional exercise of power under the Commerce Clause. The constitutionality of federal legislation under the Commerce Clause is determined by a two-part test. Congress must

(1) have a rational basis to find that the regulated activity affects interstate commerce, and (2) select a means of regulation reasonable and appropriate to achieve that end. *Atlanta Motel v. United States,* 379 U.S. 241, 258-259 (1964). *See also McCulloch v. Maryland,* 17 U.S. (4 Wheat.) 316, 421 (1819).

Defendant does not dispute that Congress could rationally determine that employee benefit plans affect interstate commerce.[16] Rather, he purports to challenge the means of regulation chosen by Congress. Specifically, he contends that full federal preemption of state regulation of employee benefit plans under Section 514(a) is unreasonable and inappropriate[17] in that the Tenth Amendment to the federal Constitution[18] precludes such a broad substitution of national for local regulation.

When fairly viewed, this argument concedes the substantive due process challenge and posits a different question: Whether an otherwise valid exercise of Congressional power under the Commerce Clause is subject to limitation under the Tenth Amendment. The answer is little disputed. Courts have repeatedly held that the Tenth Amendment

16. Congress stated its findings with respect to the effect of employee benefit plans on interstate commerce in Section 2(a) of ERISA, 29 U.S.C. § 1001(a).

17. In fact, defendant disputes more broadly the reasonableness of what he perceives to be Section 514(a)'s "wholesale invalidation of State law in the area of health care." As this case involves only the question of whether Section 514(a) of ERISA preempts defendant's attempted regulation of plaintiffs' employee benefit plans under Knox-Keene, rather than a determination of the full breadth of the preemption clause, see n. 10 *supra,* the Court rendered its judgment upon and addresses here only the limited issue.

18. The Tenth Amendment states:

> "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

imposes no limitation on Congress's application of the commerce power to private activity.[19]

The Supreme Court stated in *Case v. Bowles,* 327 U.S. 92 (1946):

> "[T]he Tenth Amendment 'does not operate as a limitation upon the powers, express or implied, delegated to the national government' [footnote omitted].
>
> "Where, as here, Congress has enacted legislation authorized by its granted powers, and where at the same time, a State has a conflicting law which but for the congressional Act would be valid, the Constitution marks the course for courts to follow. Article VI provides that 'The Constitution and the Laws of the United States • • • made in Pursuance thereof • • • shall be the supreme Law of the Land • • •' [footnote omitted]." 327 U.S. at 102-103.

In *Oklahoma v. Atkinson Co.,* 313 U.S. 508 (1941), the Supreme Court also stated:

> "The Tenth Amendment does not deprive 'the national government of authority to resort to all means for the exercise of a granted power which are appropriate and plainly adapted to the permitted end' [citations omitted] Since the construction of this dam and reservoir is a valid exercise by Congress of its commerce power, there is no interference with the sovereignty of the state [footnote omitted]." 313 U.S. at 534.

19. It is clear that the Tenth Amendment may restrict the ability of Congress to regulate states under the commerce power in a manner that adversely affect the states' sovereignty by impairing the states' integrity or their ability to function effectively in a federal system. *See National League of Cities v. Usery,* ..... U.S. ....., 96 S.Ct. 2465, 2468-2474 (1976); *Fry v. United States,* 421 U.S. 542, 547 n. 7 (1975). However, in the instant case, the Court is concerned only with federal regulation in the private sector and as Section 4(b)(1) of ERISA, 29 U.S.C. § 1003(b)(1), expressly exempts from its coverage "governmental plan[s]," such a dramatic infringement of state sovereignty is not present here.

Here, where Congress has legitimately concluded that employee benefit plans so affect interstate commerce as to warrant federal intervention, and it has reasonably determined that the preemption of contemporaneous state legislation is necessary to accomplish its legislative purposes, the Tenth Amendment poses no bar to ERISA's operation.

Accordingly, having determined that state regulation of the plaintiffs' ERISA-covered employee benefit plans under Knox-Keene is expressly and validly preempted by Section 514(a) of ERISA, the Court on November 30, 1976, granted summary judgment in favor of plaintiffs.

Dated: January 24, 1977.

/s/ CHARLES B. RENFREW
Charles B. Renfrew
United States District Judge

Appendix C

United States Constitution
Article 1, Section 8, Clause 3

To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes;

Article 6, Clause 2

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the Supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

Amendment X

The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

STATUTES

McCarran-Ferguson Act
(Public Law 15, 59 Stat. 33
as amended by 61 Stat. 448, 15
U.S.C. (Supp. V) § 1011 *et seq.*)

Section 1011:

Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

Section 1012:

(a) The business of insurance and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Employee Retirement Income Security Act of 1974

(Public Law 93-406 88 Stat. 832,
29 U.S.C. (Supp. V) 1001 *et seq.*)

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

Subtitle A—General Provisions

FINDINGS AND DECLARATION OF POLICY

Sec. 2. (a) The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a

national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operations, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) It is hereby further declared to be the policy of this Act to protect interstate commerce the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

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DEFINITIONS

SEC. 3. For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or

(B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions).

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SUBTITLE B—REGULATORY PROVISIONS

Part I—Reporting and Disclosure

DUTY OF DISCLOSURE AND REPORTING

SEC. 101. (a) The administrator of each employee benefit plan shall cause to be furnished in accordance with section 104(b) to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan—

(1) a summary plan description described in section 102(a)(1); and

(2) the information described in section 104(b)(3) and 105(a) and (c).

(b) The administrator shall, in accordance with section 104(a), file with the Secretary—

(1) the summary plan description described in section 102(a)(1);

(2) a plan description containing the matter required in section 102(b);

(3) modifications and changes referred to in section 102(a)(2);

(4) the annual report containing the information required by section 103; and

(5) terminal and supplementary reports as required by subsection (c) of this section.

• • •

PLAN DESCRIPTION AND SUMMARY PLAN DESCRIPTION

SEC. 102. (a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 104(b). The summary plan deescription shall include the information described in subsection (b), shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) shall be writtten in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 104(b)(1).

(2) A plan description (containing the information required by subsection (b)) of any employee benefit plan shall be prepared on forms prescribed by the Secretary, and shall be filed with the Secretary as required by section 104(a)(1). Any material modification in the terms of the plan and any change in the information described in subsection (b) shall be filed in accordance with section 104(a)(1)(D).

(b) The plan description and summary plan description shall contain the following information: The name and type of administration of the plan; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility

for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of this Act).

ANNUAL REPORTS

SEC. 103. (a)(1)(A) An annual report shall be published with respect to every employee benefit plan to which this part applies. Such report shall be filed with the Secretary in accordance with section 104(a), and shall be made available and furnished to participants in accordance with section 104(b).

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FILING WITH SECRETARY AND FURNISHING INFORMATION TO PARTICIPANTS

SEC. 104. (a)(1) The administrator of any employee benefit plan subject to this part shall file with the Secretary—

(A) the annual report for a plan year within 210 days after the close of such year (or within such time as may be required by regulations promulgated by the Secretary in order to reduce duplicative filing);

(B) the plan description within 120 days after such plan becomes subject to this part and an updated plan

description, no more frequently than once every 5 years, as the Secretary may require;

(C) a copy of the summary plan description at the time such summary plan description is required to be furnished to participants and beneficiaries pursuant to subsection (b)(1)(B) of this section; and

(D) modifications and changes referred to in section 102(a)(2) within 60 days after such modification or change is adopted or occurs, as the case may be.

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PART 2—PARTICIPATION AND VESTING

COVERAGE

SEC. 201. This part shall apply to any employee benefit plan described in section 4(a) (and not exempted under section 4(b)) other than—

(1) an employee welfare benefit plan;

• • •

PART 3—FUNDING

COVERAGE

SEC. 301. (a) This part shall apply to any employee pension benefit plan described in section 4(a), (and not exempted under section 4(b)), other than—

(1) an employee welfare benefit plan;

• • •

ESTABLISHMENT OF PLAN

SEC. 402. (a)(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

• • •

ESTABLISHMENT OF TRUST

SEC. 403. (a) Except as provided in subsection (b), all assets of an employee benefit plan shall be held in trust by one or more trustees. Such trustee or trustees shall be either named in the trust instrument or in the plan instrument described in section 402(a) or appointed by a person who is a named fiduciary, and upon acceptance of being named or appointed, the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan. . . .

• • •

FIDUCIARY DUTIES

SEC. 404. (a)(1) Subject to sections 403 (c) and (d), 4042, and 4044, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title.

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EFFECT ON OTHER LAWS

SEC. 514. (a) Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 506 of this Act.

(4) Subsection (a) shall not apply to any generally applicable criminal law of a State.

(c) For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.

(d) Nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 111 and 507(b)) or any rule or regulation issued under any such law.

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Knox-Keene Health Care Service Plan Act of 1975
(California Stats. 1975, ch. 941, p. 2071,
operative July 1, 1976,
Cal.Health and Safety Code § 1340 et seq.)

1340. This chapter shall be known and may be cited as the Knox-Keene Health Care Service Plan Act of 1975.

1341. Responsibility for the administration and enforcement of this chapter is vested in the Commissioner of Corporations. All references to commissioner in this chapter shall be references to the Commissioner of Corporations and all references to department shall be references to the Department of Corporations.

1342. It is the intent and purpose of the Legislature to promote the delivery of health and medical care to the people of the State of California who enroll or subscribe for the services rendered by a health care service plan or specialized health care service plan by:

(a) Assuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional patient professional relationship of trust and confidence.

(b) Assuring that subscribers and enrollees are educated and informed as to the benefits and services available so as to enable a rational consumer choice in the marketplace.

(c) Protecting the potential subscriber or enrollee from fraudulent solicitations, deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public.

(d) Help assure the best possible health care for the public at the lowest possible cost by transfering the financial risk of health care from the patient to the providers.

(e) Promoting effective representation of the interests of subscribers and enrollees.

(f) Assuring the financial stability thereof by means of proper regulatory procedures.

(g) Assuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.

1343. (a) The provisions of this chapter shall apply to health care service plans and specialized health care service plans as defined in subdivisions (f) and (m) of Section 1345.

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1344. (f) "Health care service plan" means any person who undertakes to arrange for the provision of health care services, including basic health care services, to subscribers or enrollees, or to pay for or to reimburse any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees, and who does not substantially indemnify subscribers or enrollees for the cost of provided services.

• • •

1357. (a) It is unlawful for any person to act as a solicitor or solicitor firm in this state unless such person has first secured from the commissioner a license, then in effect, authorizing such person to do so, or unless such person is exempted pursuant to the provisions of Section 1343, except that any person who files an application for a solicitor or solicitor firm license, and who pays the fee prescribed by this section on or before July 15, 1976, may act in the capacity for which such license application is filed until such time as the application is denied by the commissioner.

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1360. (a) No plan, solicitor, solicitor firm, or representative shall use or permit the use of any advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive.

• • •

1363. (a) The commissioner shall require for use by each plan disclosure forms or materials containing such information regarding the benefits, services, and terms of the plan contract as the commissioner may require, so as to afford the public, subscribers, and enrollees with a full

and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The commissioner may require that such materials be presented in a reasonably uniform manner so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the commissioner from permitting such disclosure form to be included with the evidence of coverage or plan contract.

The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with such additional information as may be required by the commissioner, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan.

(2) The exceptions, reductions, and limitations that apply to such plan.

(3) The full premium cost of such plan.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan.

(5) The terms under which the plan may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability which is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of such choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(b) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide such individual with a properly completed disclosure form, as prescribed by the commissioner pursuant to this section for each plan so examined or sold.

(c) In the case of group contracts, the completed disclosure form shall be presented to the contract holder upon delivery of the completed health care service plan agreement.

(d) Group contract holders shall disseminate copies of the completed disclosure form to all persons eligible under the group contract at the time such persons are offered the plan. Where the individual group members are offered a choice of plans, seperate disclosure forms shall be supplied for each plan available.

1364. Where the commissioner finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information disseminated by a plan for the purpose of influencing persons to become members of a plan shall contain such supplemental disclosure information as the commissioner may require.

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1367. Each health care service plan, and where applicable, each specialized health care service plan, shall meet the following requirements:

(a) All facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health, if such licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) All personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where such licensure or certification is required by law.

(c) All equipment required to be licensed or registered by law shall be so licensed or registered and the operating personnel for such equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at such times as may be appropriate consistent with good professional practice.

(e) All services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) All contracts with subscribers and enrollees, including group contracts, and all contracts with providers, subsequent providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter.

(i) Each health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the commissioner may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from such requirement. The commissioner shall by rule define the scope of each basic health care service which health care service plans shall be required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that such copayments, deductibles, or limitations are reported to, and held unobjectionable by, the commissioner and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

Nothing in this section shall be construed to permit the commissioner to establish the rates charged subscribers and enrollees for contractual health care services.

1368. (a) Every plan shall establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations which shall insure adequate consideration of enrollee grievances and rectification when appropriate.

(b) Every plan shall inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. Such information shall include the location and telephone number where grievances may be submitted.

(c) Every plan shall provide forms for complaints to be given to subscribers and enrollees who wish to register written complaints. The form shall be approved by the commissioner in advance as to format.

(d) The plan shall keep in its files all copies of complaints, and the responses thereto, for a period of five years.

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1369. Every plan shall establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan. For purposes of this section, public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public.

Compliance with the requirements of the Health Maintenance Organization Act of 1973 (42 U.S.C. § 300e et seq.) shall be deemed sufficient compliance with this section.

1370. Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

1371. Every plan shall submit to the commissioner in the annual report required in Section 1383 such information as shall be uniformly required of all health care service plans or when applicable, all specialized health care service plans and the commissioner may classify plans for such

purposes. In establishing the requirements of the statistical report, the commissioner shall consider the costs of the plans in compiling and reporting the information.

• • •

1373. (a) A plan contract may not provide an exception for other coverage where such other coverage is entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14500) of Part 3 of Division 9 of the Welfare and Institutions Code.

Each plan contract shall be interpreted not to provide an exception for such Medi-Cal benefits.

A plan contract may not provide that the benefits payable thereunder are subject to reduction if the individual insured has entitlement to such Medi-Cal benefits.

(b) A plan contract which provides coverage, whether by specific benefit or by the effect of general wording, for sterilization operations or procedures shall not impose any disclaimer, restriction on, or limitation of, coverage relative to the covered individual's reason for sterilization.

As used in this section, "sterilization operations or procedures" shall have the same meaning as that specified in Section 10120 of the Insurance Code.

(c) Every plan contract which provides coverage to family members or dependents of the subscriber or enrollee shall grant immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant, and to each minor adopted child from and after the moment the child is placed in the custody of the adoptive parents for adoption, of any subscriber or enrollee covered. No such plan may be entered into or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn infants of a sub-

scriber or enrollee covered from and after the moment of birth or of minor adopted children from and after the moment the child is placed in the custody of the adoptive parents for adoption.

(d) Every plan contract which provides that coverage of a dependent child of a subscriber shall terminate upon attainment of the limiting age for dependent children specified in the plan, shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the subscriber for support and maintenance, provided proof of such incapacity and dependency is furnished to the plan by the member within 31 days of the request for such information by the plan or group plan contract holder and subsequently as may be required by the plan or group plan contract holder, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(e) A plan contract which provides coverage, whether by specific benefit or by the effect of general wording, for both an employee and one or more covered persons dependent upon such employee and provides for an extension of such coverage for any period following a termination of employment of the employee shall also provide that such extension of coverage shall apply to dependents upon the same terms and conditions precedent as applied to the covered employee, for the same period of time, subject to payment of premiums, if any, as required by the terms of the policy and subject to any applicable collective-bargaining agreement.

(f) A group contract shall not discriminate against handicapped persons or against groups containing handicapped persons. Nothing in this subdivision shall preclude reasonable provisions in a plan contract against liability for services or reimbursement of the handicap condition or conditions relating thereto, as may be allowed by rules of the commissioner.

(g) Every group contract shall set forth the terms and conditions under which subscribers and enrollees may remain in the plan in the event the group ceases to exist, the group contract is terminated or an individual subscriber leaves the group, or the enrollees' eligibility status changes.

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Article 6. Operation and Renewal Requirements and Procedures

1375. (a) Except as provided in subdivision (d), every plan shall maintain an agreement, held unobjectionable by the commissioner, with an unrelated subsequent provider who may be an insurer, a health facility or medical service corporation, another licensed plan, or a governmental organization to provide the payment of the cost of the originally contracted health care service or to provide the originally contracted health care service in the event the plan ceases to do business, because of business failure, suspension of or revocation of its license, or any other reason. For purposes of this section, "unrelated subsequent provider" means a person who is not, directly or indirectly, controlled by, under common control with, or in control of the plan or of any officer, director, employee, or person providing financial support of the plan. Upon a finding by the commissioner that the purposes of this chapter and the

public interest are fully served, the commissioner may waive the requirement that the subsequent provider shall be an unrelated entity.

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1377. (a) Every plan which reimburses providers of health care service that do not contract in writing with the plan to provide health care services for a specified consideration, or which reimburses its subscribers or enrollees for expenditures incurred in having received health care service from providers that do not contract with the plan, in an amount which exceeds 10 percent of its total expenditures for health care services for the immediately preceding two calendar quarters, shall either (1) maintain cash or equivalents at least equal to the aggregate sum of the last four months of reimbursable payments which were made and accrued to such providers of service and its subscribers and enrollees, or (2) maintain adequate insurance to compensate for any loss resulting from the insolvency of the plan; provided however, that the commissioner may waive or reduce these requirements to such amount as the commissioner deems sufficient to protect subscribers and enrollees of such plan. Every plan shall promptly report to the commissioner whenever such reimbursables exceed 10 percent of its total expenditures for health care services over the immediately preceding two calendar quarters.

(b) Every plan which reimburses providers of health care service on a fee-for-services basis; or which directly reimburses its subscribers or enrollees, to an extent exceeding 10 percent of its total payments for health care services, shall estimate and record in the books of account a liability for incurred and unreported claims. Upon a determination by the commissioner that the estimate is inadequate, the

commissioner may require the plan to increase its estimate of incurred and unreported claims. Every plan shall promptly report to the commissioner whenever such reimbursables exceed 10 percent of its total expenditures for health care services.

As used herein the term "fee-for-services" refers to the situation where the amount of reimbursement paid by the plan to providers of service is determined by the amount and type of service rendered by the provider of service.

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1379. (a) Every contract between a plan and a provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan.

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1399.5 It is the intent of the Legislature that the provisions of this chapter shall be applicable to any private or public entity or political subdivision which, in return for a prepaid or periodic charge paid by or on behalf of a subscriber or enrollee, provides, administers or otherwise arranges for the provision of health care services, as defined in this chapter, unless such entity substantially indemnifies subscribers and enrollees for the cost of provided services and is organized and operating pursuant to a certificate issued by the Insurance Commissioner.

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California Administrative Code
(Title 10, ch. 3, subch. 5.5: Regulations
promulgated under the Knox-Keene Health Care
Service Plan Act of 1975)

1300.75. Agreements with Subsequent Providers. (a) Generally, an agreement with a subsequent provider will not be held unobjectionable unless it is demonstrated to the Commissioner that the subsequent provider (1) is unrelated to the Plan; (2) is capable, if the agreement so provides, of rendering the originally contracted health care services without significant impairment in the quality of services to Plan members; and (3) is capable of withstanding the financial burdens which may arise under the agreement.

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1300.76. Plan Tangible Net Equity Requirement. (a) Each Plan licensed pursuant to the provisions of the Act shall, at all times, have and maintain a tangible net equity at least equal to the following minimum amounts in relation to the number of enrollees entitled to health care services under contracts issued by the Plan.

Number of Enrolees	*Amount of Tangible Net Equity*
5,000 or less	$ 10,000
5,001 to 7,000	15,000
7,001 to 9,000	20,000
9,001 to 11,000	25,000
11,001 to 20,000	30,000
20,001 to 40,000	40,000
40,001 to 60,000	50,000
60,001 to 80,000	60,000
80,001 to 100,000	70,000
100,001 to 120,000	80,000
120,001 to 140,000	90,000
140,001 to 160,000	100,000
160,001 to 180,000	110,000
180,001 to 200,000	120,000
200,001 to 300,000	170,000
300,001 to 400,000	220,000
400,001 to 500,000	270,000
500,001 to 600,000	320,000
600,001 and above	370,000

(b) For the purpose of this section "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the Commissioner. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill, going concern value, organizational expense, starting-up costs, obligations of officers, directors, owners, or affiliates which are not fully secured other than securities of the plan or an affiliate, long term prepayments of deferred charges and nonreturnable deposits.

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Appendix D

United States District Court for the District of New Hampshire

Civil Action No. 76-266

JAMES M. DAWSON, etc., et al.

v.

FRANCIS E. WHALAND, etc.

ORDER

Plaintiffs are administrators of employee health and welfare funds, all but one of which, the New Hampshire Employers' Benefit Trust, are "Taft-Hartley Trusts" established under 29 U.S.C. § 186(c).

The defendant, the State of New Hampshire, has recently enacted Chapter 57 of the Laws of 1976, RSA 415:18-a, 419:5-a, and 420:5-a, which mandates coverage of mental and nervous conditions in group health and accident insurance policies.

The plaintiffs claim that the New Hampshire statute violates the United States Constitution and that it is preempted by federal statutes in the instances of the Taft-Hartley Trusts.

The plaintiffs allege that several provisions of Chapter 57 violates the equal protection and due process provisions of the Fourteenth Amendment. The case is before this court on cross-motions for summary judgment.

In determining whether Chapter 57 violates the Equal Protection Clause, I must uphold the legislative classification unless it is patently arbitrary and bears no rational relationship to a legitimate governmental interest. *U.S. Dept. of Agriculture v. Moreno,* 413 U.S. 528 (1973); *Frontiero v. Richardson,* 411 U.S. 677 (1973); *San Antonia Independent School District v. Rodriguez,* 411 U.S. 1 (1973); *Dandridge v. Williams,* 397 U.S. 471 (1970); *Turner v. Fouche,* 396 U.S. 346 (1970). "This inquiry employs a relatively relaxed standard reflecting the Court's awareness that the drawing of lines that create distinctions is peculiarly a legislative task and an unavoidable one." *Massachusetts Board of Retirement v. Murgia,* 44 U.S.L.W. 5077 (1976). I look to the character of the classifications in question, individual interests affected by classification, and governmental interests asserted in support of classification, and governmental interests asserted in support of classification. *Dunn v. Blumenstein,* 405 U.S. 330 (1972). In doing so, I note that the exercise of the police power with regard to enforcement of health and insurance regulations is almost always upheld. *Cf. Hoopston Canning Co. v. Cullen,* 318 U.S. 313 (1943); *Bourjois v. Chapman,* 301 U.S. 183 (1937); *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania,* 481 F.2d 80 (3d Cir. 1973), *cert. den.,* 414 U.S. 1093 (1973); *Iowa National Mutual Insurance Company v. City of Osawatomie, Kansas,* 458 F.2d 1124 (10th Cir. 1972); *Wissner v. Metropolitan Life Insurance Company,* 395 F. 2d 204 (5th Cir. 1968); *Guest v. Fitzpatrick,* 409 F.Supp. 818 (E.D. Pa. 1976); *King v. Blue Mountain Forest Association,* 100 N.H. 212 (1956); *State v. Normand,* 76 N.H. 541 (1913). Justice Holmes stated with regard to the guarantees of the Fourteenth Amendment and the reservation of the police powers to the State:

> [W]e must be cautious about pressing the broad words of the Fourteenth Amendment to a drily logical extreme. Many laws which it would be vain to ask the court to overthrow could be shown, easily enough, to transgress a scholastic interpretation of one or another of the great guaranties in the Bill of Rights. They more or less limit the liberty of the individual or they diminish property to a certain extent. We have few scientifically certain criteria of legislation, and as it often is difficult to mark the line where what is called the police power of the States is limited by the Constitution of the United States, judges should be slow to read into the latter a *nolumus mutare* as against the law-making power. *Noble State Bank v. Haskell,* 219 U.S. 104, 110 (1911).

The question of standing always looms in the background of an equal protection claim. It is axiomatic that one does not have standing to assert the rights of another. *Tileston v. Ullman,* 318 U.S. 44 (1943). In order to satisfy the constitutional requirement for a case or controversy:

> [t]he controversy must be definite and concrete, touching the legal relations of parties having adverse legal interests. *Aetna Life Insurance Co. v. Haworth,* 300 U.S. 227, 240 (1937).

Plaintiffs also raise a vagueness issue under the due process claim.

1. *Residence and Place of Employment*

Plaintiffs complain that the statute discriminates against them by "compelling only those who are residents and have their principal place of employment in New Hampshire to procure mental health insurance . . . ."

Chapter 57:1(I) of the 1976 Laws states in pertinent part:

> Each insurer . . . shall provide to each group, or the portion of each group comprised of certificate holders of such insurance *who are residents of this state and whose principal place of employment is in this state,* coverage for expenses arising from the treatment of mental illness . . . . (Emphasis added.)

The statute, far from discriminating, applies equally to all those within the jurisdiction. It is basic constitutional law that a state can only regulate as to those within its jurisdiction. While this may impose additional burdens on residents as opposed to those outside the jurisdiction, this is not a constitutional defect.

2. *Blue Cross-Blue Shield*

Plaintiffs complain that Blue Cross-Blue Shield is granted significant advantage over other insurers by Chapter 57: 2(VI) of the Laws of 1976 which states:

> In the case of care and services rendered by licensed general hospitals, public or licensed mental hospitals, or community mental health centers which have not entered into a written contract with the hospital service corporation for the rendering of such care and services to its subscribers, benefits of not less than 75 percent of the benefits enumerated in paragraphs I, II, and III shall be provided.

The plaintiffs are not insurance companies; so even if this provision does discriminate, they are not in a position to complain. If Blue Cross-Blue Shield is given a superior position as a result of this statute, the plaintiffs are free to do business with Blue Cross-Blue Shield. In short, plaintiffs do not have standing to raise this issue.

3. *Group Versus Individual Policies*

Chapter 57:1(I) of the 1976 Laws creates a statutory classification of "group or blanket accident or health insurance policies." The plaintiffs allege that it is unconstitutional to require purchasers of group insurance to purchase mental health insurance since there is no similar requirement for purchasers of individual policies.

The issue is whether there is a rational basis for the mental health insurance requirement for purchasers of group insurance.

The State has determined that there is a grave need for mental health insurance but, because of the higher cost of individual policies, mental insurance benefits are more likely to be economically feasible in a group plan which can take advantage of group, rather than national, actuarial statistics and the combined economic power of the group. This is clearly "a rational basis."

4. *Difference Between Billing Procedures for Psychiatrists and Psychologists from Other Physicians*

Plaintiffs complain that the billing procedures mandated for psychiatrists and psychologists are different from those of physicians and, therefore, unconstitutional. Plaintiffs are not physicians and do not have standing to raise this issue.

5. *First Dollar Charges*

Plaintiffs claim an equal protection violation by Section 1(III)(d) of Chapter 57 of the 1976 Laws which states:

> Benefits for outpatient services under this paragraph need not be provided for the first or second visit providing such a limitation applies in the case of services for other illnesses, and benefits for out-patient

> treatment may be otherwise limited to not less than 15 full hours of treatment in any consecutive 12-month period.

Plaintiffs interpret this statute to mean that "first and second office visits must be paid unless there are at least 15 full hours of insured mental health treatment in any 12-month period." They contend that there is a distinction made between mental illness and other illnesses and that there must be a rational basis for this distinction. Although I do not concur with plaintiffs' interpretation of the statute, it is plain that the provision does make a distinction between the two categories of illness. This is not a distinction that violates the Equal Protection Clause of the Fourteenth Amendment. The legislature, in its wisdom, has seen fit to give more protection to those with mental problems than those with physical problems. Perhaps they felt that those with physical problems already had adequate protection without further legislative intervention: perhaps they felt that the risk sharing element of insurance should be applied to mental illnesses because of the large expenses incurred by a victim and his family and the potential exposure of all families. In any event, there is a rational basis for this provision which falls within the police power of the State of New Hampshire.

6. *Vagueness*

The plaintiffs allege that Chapter 57 violates the Due Process Clause of the Fourteenth Amendment because it is unduly vague. They contend that NH RSA 400-A:15(III), which makes it a crime to violate rules, regulations or order

of the Insurance Commissioner, applies to them.[1] It is not clear that this criminal statute applies to insurance statutes as opposed to rules. If it does, the violator would be the insurance carrier, not the plaintiffs here. Therefore, once again, plaintiffs do not have standing to sue.

7. *Impairment of Contract*

Plaintiffs allege that Chapter 57 impairs their constitutional right to contract. In *City of El Paso v. Simmons,* 379 U.S. 497 (1965), the Court held that the constitutional prohibition against impairment of contracts is qualified by the measure of control which the states retain over remedial processes and that the states also have authority to safeguard vital interests of their citizens even if legislation appropriate to that end has the effect of modifying or abrogating contracts already in effect. That holding is directly on point here.

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1. The statute is set out below.

400-A:15 Rules and Regulations; Violation.

I. The commissioner shall have full power and authority to make, promulgate, amend and rescind reasonable rules and regulations for, or as an aid to, the administration or effectuation of any provision or provisions of this title and such other rules and regulations as are reasonably necessary to implement the provisions of this title.

II. Prior to the adoption of any rule or regulation, or the amendment or repeal thereof, the commissioner shall publish or otherwise circulate notice of his intended action and afford interested persons opportunity to submit data or views either orally or in writing.

III. Any person who knowingly violates any rule, regulation, or order of the commissioner may, upon hearing, except where other penalty is expressly provided, be subject to such suspension or revocation of certificate of authority or license, or administrative fine not to exceed $2,500 in lieu of such suspension or revocation, as may be applicable under this title for violation of the provision to which such rule, regulation, or order relates.

8. *Interstate Commerce and Preemption*

Plaintiffs' final constitutional claim is that Chapter 57 interferes with Congress' authority to regulate interstate commerce. This constitutional issue is much the same as the preemption issue. The question is whether Congress has chosen to preempt the field.

> [F]ederal regulation of a field of commerce should not be deemed preemptive of state regulatory power in the absence of persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained. *Florida Avocado Growers v. Paul,* 373 U.S. 132 (1962).

All of the plaintiff trusts except the New Hampshire Employers' Benefit Trust are Taft-Hartley Trusts and subject to the various provisions of Title 29. Plaintiffs complain that Chapter 57 has been preempted on two separate bases: (a) it interferes with the congressional purpose in ERISA by fostering conflicting state laws; and (b) it is specifically preempted by statute.

a. *Conflicting State Statutes*

The trusts in question here are subject to the provisions of 29 U.S.C. § 186. Subsection (c)(5) of that section provides that monies paid to the fund be used "for the sole and exclusive benefit of the employees of such employer, and their families and dependents . . . ." This language has been construed to require fair and equal administration by the fiduciaries of such funds. *Bey v. Muldoon,* 223 F. Supp. 489 (E.D. Pa. 1963).

The beneficiaries of the funds in this case are not all from New Hampshire. They are, therefore, not within the scope of Chapter 57. Plaintiffs assert that if Chapter 57 is followed for New Hampshire beneficiaries, then it must

be followed for all beneficiaries. This not only extends New Hampshire jurisdiction beyond its territorial limit, but it runs the risk of conflicting with other jurisdictions which might have different insurance requirements.

This argument is flawed by a false premise. Plaintiffs have attempted a quantum leap by asserting that the requirement of fair and equal administration means that beneficiaries from different jurisdictions must all receive the same precise policies. There is no legal basis for this presumption. The evidence shows that employer and employee contributions to the funds are negotiated by the international unions and that the exact terms of the insurance contracts are chosen by the members of one or more locals. I don't doubt that the State of New Hampshire has created an additional burden for the administrators who may have to furnish two seperate plans for the members of each local which is comprised of employees from more than one jurisdiction, but Congress would not have knowingly preempted the insurance field without providing for it more specifically.

b. *Statutory Preemption*

Plaintiffs' other preemption argument is somewhat more direct.

Section 514 of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1144, preempts state laws that relate "to any employee benefit plan . . . ."

> [T]he provisions of this title . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . . 29 U.S.C. § 1144(a).

Employee benefit plans include both retirement funds and health and accident funds of the type which the plaintiffs administer. 29 U.S.C. § 1002(3).

To the sweeping preemption language, Congress created an exception:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. 29 U.S.C. § 1144(b)(2)(A).

Plaintiffs claim that there is an exception to this exception contained at 29 U.S.C. § 1144(b)(2)(B).

> Neither an employee benefit plan . . ., nor any trust established under such plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company, or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

There is little or no published legislative history surrounding the words in this subsection which help me interpret it.[2] Plaintiffs would have me read this language to preempt Chapter 57, but the plain meaning of the language is that states may not regulate employee benefit plans by calling them insurance companies. This more limited reading is bolstered by 15 U.S.C. § 1012(B).

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2. I have reviewed the parts of the House, Senate, and Conference Reports which concern preemption as well as the hearings before the respective House and Senate Committees and the floor statements of Senator Harrison Williams and Representative John Dent, Chairman of their respective committees, and statements of other Congressmen. None of these addressed the question of preemption of substantive insurance statutes which regulate benefits, not financial or recording requirements. The complete lack of discussion of the effect of preemption of state regulations which concern actual insurance benefits aids in my conclusion that there was no preemption intended in this field.

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . . 15 U.S.C. § 1012(B).

ERISA is not primarily concerned with the regulation of insurance. ERISA is a broad act, the parts of which are important here deal almost exclusively with reporting provisions to ensure the financial health of employee benefit trusts. The remainder of ERISA deals mostly with tax aspects of retirement funds, contributions to them, and payments from them. Even without the exception for insurance regulation at 29 U.S.C. § 1144(b)(2)(A), the effect of 15 U.S.C. § 1012 is to except insurance regulation from preemption. The exception makes the intent not to preempt even clearer.

The New Hampshire statute imposes mental health insurance on those participating in group insurance plans. It neither seeks to nor in any way effects the administration of employee benefit plans. This decision is distinguished from the rulings in *Azzaro, et al. v. Harnett,* C. 75-361 (S.D. N.Y. 1976), and *Hewlett-Packard Co. v. Barnes,* C. 76-1607 (N.D. Cal. 1976), because the state statutes in those cases were financial disclosure, quality control, and general reporting statutes, not general insurance statutes regulating the form of benefits. They were designed to effect the administration and implementation of group plans and were directly preempted by ERISA.

Judgment is entered for the defendant on all counts. SO ORDERED.

/s/ HUGH H. BOWNES
United States District Judge

February 11, 1976